

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

61-022732  
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5619**

AMENDED

FILED JUN 20 1961

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY	c. CITY OR TOWN		Inside Limits	
b. COUNTY		St. Louis			Illinois		St. Clair	East St. Louis		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits	d. STREET ADDRESS (If outside, give location).			Reside on Farm			
Incarnate Word Hospital				Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	804 St. Williams Dr.			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH		5. AGE (last birthday)			
Margaret Hunter						June 14, 1961		71			
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR	
Female	White			1/14/1890		71		Months	Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY			
Housewife			At Home			Houston, Ill.		U.S.			
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE			
John Short				Eva Lessley				Edward Hunter			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT					
No				None		Juanita Theobald, 804 St. Williams Dr.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <i>Carcinoma Lung &amp; Metastases</i>										8 mos	
DUE TO (b) <i>Adenocarcinoma Endometrium</i>										6 1/2 yrs	
DUE TO (c) <i>172X</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)										PART III. If deceased was female was there a pregnancy in last 90 days.	
										<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)							
20c. TIME OF INJURY		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
Hour a.m. p.m.		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)									
		20f. CITY, TOWN, OR LOCATION									
		COUNTY									
		STATE									
21. I attended the deceased from <u>195-7</u> to <u>14 June 61</u> and last saw her alive on <u>13 June 61</u> Death occurred at <u>2 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title)						22b. ADDRESS			22c. DATE SIGNED		
<i>Albert A. Berganti M.D.</i>						<i>111 So. Main Ave. Chicago</i>			<i>14 June 61</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county)				
Removal		6-17-61		Cutler Cemetery			Cutler, Ill.				
24. FUNERAL DIRECTOR					25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE				
Albert H. Hoppe, Inc., 4700 Washington Blvd.					JUN 15 1961		<i>Loan Smith M.D.</i>				

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Elmo R. Sadwell

Licensed Embalmer No. 4977  
P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.